DOCUMENT RESUME

ED 379 271 SP 035 802

TITLE	Health Care: School-Based Health Centers Can Expand Access for Children. Report to the Chairman, Committee on Government Operations, House of Representatives.
INSTITUTION	General Accounting Office, Washington, DC. Health, Education, and Human Services Div.
REPORT NO	GAO/HEHS-95-35
PUB DATE	Dec 94
NOTE	55p.
AVAILABLE FROM	U.S. General Accounting Office, P.O. Box 6015, Gaithersburg, MD 20884-6015 (single copy free, additional copies $2; 100 or more are discounted 25 percent; order should be accompanied by check or money order made out to the Superintendent of Documents).
PUB TYPE	Reports - Evaluative/Feasibility (142)
EDRS PRICE	MF01/PC03 Plus Postage.
DESCRIPTORS	*Agency Cooperation; Case Studies; Cooperative Programs; Elementary Secondary Education; *Integrated Services; *Program Effectiveness; Program Evaluation; *School Community Programs; *School Health Services; Social Services
IDENTIFIERS	*Comprehensive School Health Programs

ABSTRACT

This report reviews the role of school-based health centers (SBHCs) in expanding children's access to health care, and examines financial and other obstacles SBHCs must overcome. The report is based on a literature review; interviews with officials; and case studies conducted at eight SBHCs in California, New Mexico, and New York. The study found that state, local, and private funds supply most of the financing for centers; several federal programs (primarily Medicaid and the Maternal and Child Health Block Grant program) supplement these funds. SBHCs were found to offer children easier access to needed health services by bringing providers to the children, furnishing free or low-cost services, and supplying the atmosphere of trust and confidentiality adolescents need. SBHCs do not, however, provide all health services required by students and cannot reach adolescents who have dropped out of school. Major concerns for SBHCs include a lack of stable financing, recruitment and retention of appropriately trained nurse practitioners and physician assistants, controversy over providing reproductive health services, and difficulty in obtaining guidance on establishing SBHCs or solving problems at existing centers. Research measuring the impact of SBHCs on health and education outcomes is sparse. An appendix contains descriptions of the SBHCs studied. (JDD)

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United States General Accounting Office

GAO

Report to the Chairman, Committee on Government Operations, House of Representatives

December 1994

ED 379 271

HEALTH CARE

School-Based Health Centers Can Expand Access for Children

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United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-252731

December 22, 1994

The Honorable John Conyers, Jr.
Chairman, Committee on Government
Operations
House of Representatives

Dear Mr. Chairman:

This report, prepared at your request, reviews the role of school-based health centers in expanding children's access to health care and the financial and other obstacles school centers must overcome to launch and maintain their services.

We are sending copies of this report to interested congressional committees and are making copies available to others on request. If you or your staff have any questions, please call me at (202) 512-7119. Other major contributors to this report are listed in appendix II.

Sincerely yours,

Mark V. Nadel

Mark V. Nadel
Associate Director, National and
Public Health Issues

Executive Summary

Purpose

American children face increasing physical and mental health risks, such as human immunodeficiency virus (HIV) infection, alcohol abuse, and suicide. Yet many children lack access to the regular health care needed to prevent disease, disability, and unnecessary hospitalization. Over nine million children lacked health insurance during 1993, and millions more were uninsured for part of the year.

A small but growing number of communities are using an innovative approach to reach children with limited access to health services. School-based health centers (SBHC) provide students with a range of preventive, medical, and mental health services, on the basis of the needs and priorities of local communities.

In response to a request from the Chairman of the House Committee on Government Operations, GAO examined (1) how school-based health centers expand access to health services for both adolescents and younger children who have had limited access to care and (2) the financial and other obstacles SBHCs must overcome to launch and maintain their services. To address these questions, GAO completed case studies at eight school-based health centers in California, New Mexico, and New York; many of these schools are in neighborhoods with high rates of poverty and health problems, including HIV infection, drug use, and tuberculosis. GAO also interviewed public and private officials who work with SBHCs and conducted a review of the literature.

Background

States and communities have responded to children's lack of access to health services by establishing several hundred SBHCs since 1980. State, local, and private funds supply most of the financing for centers; several federal programs supplement these funds. Federal funding consists primarily of reimbursement from the Medicaid program and grants from the Maternal and Child Health Block Grant program. Only a small amount of money—2 percent—comes from payments by students enrolled in SBHCs and private insurers.

Results in Brief

Communities are using school-based health centers to fill a niche in the nation's health care delivery system. SBHCs afford children easier access to needed health services by bringing providers to the children, furnishing free or low-cost services, and supplying the atmosphere of trust and confidentiality adolescents need. SBHCs do not, however, provide all health

services required by students and cannot reach adolescents who have dropped out of school.

A lack of stable financing is a major concern for SBHCs, with some centers reporting insufficient funds to meet all children's service needs. SBHCs often have difficulty obtaining reimbursement from public and private insurers, including Medicaid. States' increased use of Medicaid managed care could further reduce centers' ability to receive Medicaid payments. Centers linked with established health care providers can more easily bill insurers as well as offer more comprehensive services to students.

In addition to financial problems, SBHCs nationwide face other problems. Centers have difficulty recruiting and retaining appropriately trained nurse practitioners and physician assistants, who are their key primary care providers. Community debates over the appropriateness of providing reproductive health services in school-based centers have limited centers' ability to meet some adolescents' health needs.

Communities lack access to information on establishing new centers and solving problems at existing ones. Furthermore, research measuring the impact of SBHCs on health and education outcomes is sparse. Although efforts to coordinate school health programs within the federal government have begun, the Department of Health and Human Services (HHS) does not have a focal point to answer outside inquiries, provide technical assistance, or develop a research agenda.

Principal Findings

SBHCs Improve Children's Access to Health Care

Health and education officials believe that SBHCs improve children's access to health care by removing financial and other barriers in the existing health care delivery system. Providing health services to children in school-based settings enables children to get both periodic preventive care and treatment for chronic and acute medical conditions. SBHCs provide services either free of charge or at minimal cost to students, which can particularly help children who lack health insurance and those whose insurance may not cover all the services they need. Locating services where the children are increases convenience for students and parents. Additionally, SBHCs provide adolescents with an environment of greater trust and confidentiality than that of other health care settings.

Centers Are Concerned About Financing

SBHC staff report difficulties in financing their operations. School centers often rely on fragmented sources of funding. Private foundation funds that have played a large role in establishing new centers are frequently short term, leaving centers with an uncertain future. Because of resource limitations, some sites cannot offer care during all the days or hours the school is open. Others cannot meet the large demand for mental health and dental care.

Difficulties in billing both private and public insurers further constrain funding. Problems include centers' lack of administrative capacity, low-income families' inability to pay insurance deductibles, concern that adolescents will lose confidentiality if parents receive insurance statements, and insurers' exclusion of some needed services from coverage.

Despite serving large Medicaid-eligible populations, SBHCs do not always receive Medicaid reimbursement because of problems such as the difficulty of determining students' Medicaid eligibility and states' restrictions on services they cover. The growth of Medicaid managed care could further reduce Medicaid payments to SBHCs. Managed care providers are often reluctant to reimburse SBHCs for services provided to their members, partly because they do not control the type and quality of care provided at SBHCs.

SBHCs Face Staffing and Other Difficulties

The key health professionals at SBHCs are nonphysician primary care providers—that is, physician assistants and nurse practitioners—who are generally in short supply. SBHCs face a particularly acute shortage because their staff may need special qualifications such as bilingual ability or training in adolescent health. SBHCs have difficulty competing for staff with other health care settings, such as hospitals and health maintenance organizations, because they offer less desirable salaries and working conditions. HHS' support of training programs for school health providers may help expand the number of skilled providers capable of working in SBHCs. In addition, the National Health Service Corps' recent initiatives to place nonphysician primary care providers in underserved areas might give SBHCs a new source for staff.

Adolescents who are sexually active are at risk for problems such as unintended pregnancies and sexually transmitted diseases—including AIDS—and could benefit from reproductive health services. Some community members, however, consider it inappropriate to provide these

services in schools, and the resulting controversy has led some SBHCs to limit or eliminate family planning services. Other SBHCs have had their funding withheld.

A third problem faced by SBHCs is the difficulty communities have getting guidance on establishing SBHCs or solving the problems at existing centers. No central source of information on SBHC operations and potential funding sources exists. Although HHS supports internal coordination for federally supported school health programs, it has not established a focal point to answer outside inquiries or provide technical assistance.

Recommendations

GAO is not making recommendations in this report.

Agency Comments

Officials from several bureaus and offices in the Departments of Health and Human Services and Education reviewed a draft of this report. They generally agreed with our findings and made several technical comments and clarifications, which we incorporated as appropriate.

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Abbreviations

AIDS	acquired immunodeficiency syndrome
AAP	American Academy of Pediatrics
AMA	American Medical Association
BPHC	Bureau of Primary Health Care
CDC	Centers for Disease Control and Prevention
CPO	Center for Population Options
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HIV	human immunodeficiency virus
IDEA	Individuals with Disabilities Education Act
MCHB	Maternal and Child Health Bureau
NHSC	National Health Service Corps
OIG	Office of Inspector General
PCP	primary care provider
PHS	Public Health Service
SBHC	school-based health center
SLHC	school-linked health center
WIC	Special Supplemental Food Program for Women, Infants and Children

Communities Use School-Based Health Centers to Provide Health Services to Children

Many American children lack access to the regular health care needed to prevent disease, disability, and unnecessary hospitalization as well as to treat acute and chronic conditions. Barriers to access—such as inadequate or no health insurance, few available caregivers, and lack of convenient transportation—particularly affect poor children. Over nine million children had no health insurance during 1993, an increase of about one million uninsured children from 1992, and millions more were uninsured for parts of the year.

In response to this problem, the Chairman of the House Committee on Government Operations asked us to study an approach that a small but growing number of communities are using to deliver care to children with limited access to health services: school-based health centers. School-based health centers (SBHC) are innovative programs designed to deliver health services where the children are—in the nation's schools.[1] Located on school grounds, SBHCs provide students with a range of preventive, medical, and mental health services, on the basis of the needs and priorities of local communities. This report examines (1) how school-based health centers expand access to health services for both adolescents and younger children who have had limited access to care and (2) the financial and other obstacles SBHCs must overcome to launch and maintain their services.

Children Need Regular Health Care Services

Children of all ages need regular health services both for periodic preventive care and for treatment of chronic and acute medical conditions. Additionally, the need to provide mental health services to both adolescents and younger children is increasing.

Prevention and Treatment Needed

The American Academy of Pediatrics (AAP) and the American Medical Association (AMA) recommend that children receive a range of preventive services, including immunizations, physical assessments, developmental and behavioral assessments, dental examinations, and vision and hearing screenings.[2] Other children's health services recommended by HHS include counseling on substance abuse, diet and exercise, sexual development and behavior, and dental health; and observation of signs for abuse, neglect, or depression.

[1]In 1990, about 44.4 million school-aged children (5 to 17 years) lived in the United States.

[2]The AAP suggests that children aged 5 to 12 receive preventive services about every 2 years, and the AMA recommends that children aged 11 to 21 receive preventive services annually.

Many children also need care for serious health problems. For example, 4.1 million children aged 1 to 19 are limited in their usual activities because of chronic illnesses and impairments, including asthma and heart disease. Asthma is the most common chronic disorder among youth and is the leading cause of school absences; hospitalizations of children because of asthma have been increasing. Tuberculosis is another rapidly growing problem, and infected children require treatment to ensure that they do not develop active cases later in life.[3] Additionally, many children have severe dental problems resulting from poor nutrition and hygiene.

The health problems of adolescents often involve a complex web of physical, emotional, and social issues requiring more than simple medical care. Many of these problems, such as sexually transmitted diseases, unplanned pregnancies, and intentional and unintentional injuries, are caused by risk-taking behavior rather than specific diseases. For example, 39 percent of high school seniors reported having had five or more drinks at one time in the past 2 weeks,[4] and about 15 percent of adolescent deaths result from motor vehicle accidents involving alcohol.[5] Adolescents often need mental health services or health education to help them avoid these risky behaviors.

Children's Need for Mental Health Services Is Increasing

The need to provide mental health services to children is growing. HHS' Healthy People 2000 reports that psychological, emotional, and learning disorders are rising among children, as are reported cases of abuse and neglect.[6] In 1991, 2.7 million cases of suspected child abuse or neglect were reported. From 1960 to 1988, the suicide rate among 15- to 19-year-olds more than tripled, and the number of attempted suicides is many times higher than the number of completed suicides.[7] At one of the high schools we visited, 21 percent of the female students and 7 percent of

[3]One SBHC we visited found that over 18 percent of tested students were infected with tuberculosis. We completed case studies at eight SBHCs as part of our review. See the scope and methodology section on page 16 for more detail.

[4]National Association of State Boards of Education and the American Medical Association, National Commission on the Role of the School and the Community in Improving Adolescent Health, Code Blue: Uniting for Healthier Youth (Alexandria, Va.: 1992).

[5]Ellen L. Marks and Carolyn H. Marzke, Healthy Caring: A Process Evaluation of the Robert Wood Johnson Foundation's School-Based Adolescent Health Care Program (Princeton, N.J.: Mathtech. Inc., 1993).

[6]Healthy People 2000: National Health Promotion and Disease Prevention Objectives, HHS, Public Health Service, 91-50212 (Sept. 1990).

[7]Ann F. Garland and Edward Zigler, "Adolescent Suicide Prevention: Current Research and Social Policy Implications," American Psychologist, Vol. 48, No. 2 (1993), pp. 169-182.

the male students responding to a health survey reported having attempted suicide; 40 percent of the female students said they had seriously considered suicide at some time.

SBHC providers told us that they often encounter children who have experienced abuse, neglect, or depression and require mental health services. Mental health services account for half of all visits to New Mexico SBHCs. The providers believe that many students' problems result from family or community situations, such as parents abusing drugs or feeling the pressures of being unemployed. An elementary school mental health counselor told us that the children at his school have mental health problems such as feelings of hopelessness, depression, low self-esteem, and aggressive behavior.

Children Do Not Receive Needed Health Care

Many American children are not receiving the health care services they need. For example, about 12 million children do not get basic preventive care such as periodic physical examinations or immunizations at the proper intervals.[8] The U.S. Department of Education reported that only about half of all elementary school children routinely receive health care.[9] Although 7.5 million children under the age of 18 require mental health services, fewer than one in eight actually receive them.[10]

Poor children in particular typically receive only episodic and crisis-related care, leaving preventive, chronic, and dental health needs unmet. For example, of the 19 million children eligible for Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program in 1992, fewer than 7 million had been screened.[11]

Poor children have more health problems than other children, their conditions are often more severe, and they are less likely to receive regular health care. Over 40 percent of poor school-aged children had no dental visits in 1989, compared with 28 percent for all children. HHS has reported that 27 percent of children aged 6 to 8 and 23 percent of

[8]Robert F. St. Peter, Paul W. Newacheck, and Neal Halfon, "Access to Care for Poor Children," Journal of the American Medical Association, Vol. 267, No. 20 (May 27, 1992), pp. 2760-64.

[9]Improving America's Schools Act of 1993, U.S. Department of Education (Washington, D.C.: 1993).

[10]HHS, Healthy People 2000.

[11]EPSDT is a comprehensive, preventive health care program for Medicaid-eligible children up to age 21. It requires states to cover periodic health screenings for children, including comprehensive physical exams and health histories, as well as dental, hearing, vision, and any other health services necessary to treat conditions identified during screenings.

15-year-olds have untreated dental caries. In addition, children from poor families (those with less than $10,000 annual income) are nearly twice as likely to be hospitalized and spend more than twice the number of days in the hospital than children from higher income families ($35,000 or more annual income).

Communities Developed SBHCs to Provide Needed Care

School-based health centers, which began as a grassroots effort, have become an increasingly popular way to provide health care to needy children around the country. As of the early 1980s, about 30 SBHCs were operating in communities nationwide, and estimates of the current number of SBHCs range from over 500 to about 600.[12] Although the number of SBHCs has grown rapidly in the last decade, it represents a fraction of the nation's schools, which totaled 84,578 in 1991-1992. According to one recent survey, by the Robert Wood Johnson Foundation and Columbia University, New York has the greatest number of SBHCs—140; the remaining sites are located in 40 other states and the District of Columbia. Almost half (48 percent) of the centers serve high school students, 26 percent serve elementary school children, and 16 percent serve middle/junior high school students. The remaining 10 percent of SBHCs are located in alternative schools.[13]

Most SBHCs provide primary care, physical examinations, and injury treatment, but specific services vary by location. Other services that SBHCs may offer include immunization, counseling, laboratory tests, chronic illness management, health education, substance abuse treatment, and reproductive health care. (For more detailed information on the kinds of services that may be available at an SBHC, see fig. 1.1.) SBHCs refer students to local health providers for services that they cannot provide on site. Most SBHCs require a parental consent form, which typically allows parents to specify which services the center may provide to their children. SBHCs in elementary schools often involve parents more directly in care than those in middle and high schools because providers may need to obtain a younger child's medical history or instruct a parent on a child's medication regimen.

[12]The exact number of SBHCs is difficult to estimate because no reliable national database exists, states may be unable to track independent community-based programs, and the definition of SBHCs is imprecise. Available data sometimes combine information on SBHCs with information on school-linked health centers (SLHC), which are either located on a school campus and serve more than one school or are located off campus and may serve one or more schools.

[13]Robert Wood Johnson Foundation, Access to Comprehensive School-Based Health Services for Children and Youth (Washington, D.C.: 1994). The survey identified 608 SBHCs.

Figure 1.1: Types of Services SBHCs May Provide

Medical Services

- Comprehensive medical and psychosocial histories
- Immunizations
- Comprehensive physical examinations per EPSDT guidelines
- Developmental assessment
- Assessment of educational, achievement, and attendance problems
- Vision and hearing screening
- Dental assessment
- Referral for dental care
- Dental care
- Diagnosis and treatment of minor and acute problems
- Management of chronic problems
- Prescription of medicines for minor, acute, and chronic problems
- Dispensing of medicines for minor, acute, and chronic problems
- Laboratory testing
- Referral to medical specialty services
- Twenty-four hour coverage
- Gynecological/urological care
- Family planning services or referrals
- Contraceptive prescriptions or referrals
- Condom availability
- Pregnancy testing
- Options counseling
- Prenatal care services or referrals
- Well child care of students' children
- Referrals to well child care
- On-site STD and HIV/AIDS treatment
- Referral for STD and HIV/AIDS treatment
- HIV testing and counseling
- Referral to HIV pre/post test counseling
- Case management

Health Education/Promotion

- One-on-one patient education
- Group/targeted education at SBHC
  - Sample topics: smoking cessation
    teen parenting classes
    weight reduction seminars
- Family and community health education
- Supplemental classroom presentations and resource support for comprehensive health education
  - Sample topics as appropriate:
    - STD/HIV/AIDS education
    - pregnancy prevention
    - drug use prevention
    - intentional and unintentional injury prevention
    - chronic conditions (e.g., asthma)
    - general parenting skills

Mental Health Services

- Individual mental health assessment, treatment, and followup, including: physical/sexual abuse identification and referral
  physical/sexual abuse counseling
  substance abuse assessment
  substance abuse counseling and referrals
- Group and family counseling
- Crisis intervention
- Mental health referrals

Social Services

- Social service assessment
- Referrals to and followup with social service and other agencies for: basic needs (e.g., food, shelter, clothing)
  employment services
  legal service
  public assistance (e.g., AFDC, Medicaid)
- Case management
- On-site provision of services (e.g., food pantry)
- Transportation

SBHC Management and Funding Vary

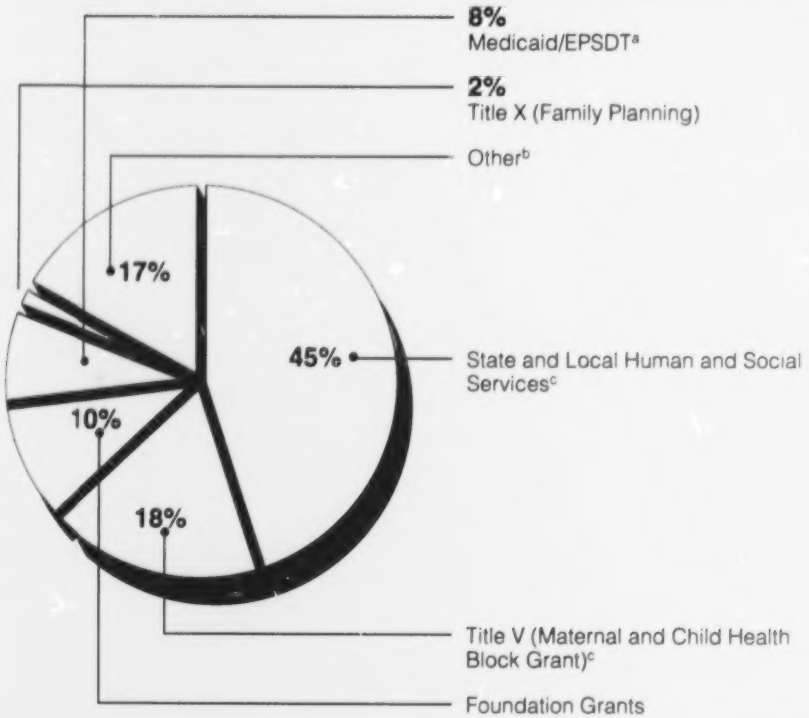
The organizations that manage SBHCs vary; they include state and local health departments, community health centers, hospitals, and school systems. Staff usually comprise an interdisciplinary team that often includes a nonphysician primary care provider, such as a nurse practitioner or physician assistant; the number and types of other personnel, such as physicians, mental health counselors, or health educators, may vary. Many SBHCs depend on links with established health facilities and donated services to provide support for their operations and to increase the range of services available onsite. While many centers are open only during the school day or the school year, over 70 percent refer patients to some other health care source for after-hours care.[14]

State, local, and private funds supply the majority of SBHC funding and are supplemented by funds from several federal programs (see fig. 1.2). Only a small amount of money comes from payments by SBHC enrollees and private insurers. Nationwide, the median SBHC budget for the 1991-92 school year was $132,500, with centers receiving on average an additional $20,000 in donated services from other providers.[15]

[14]Center for Population Options (CPO), School-Based and School-Linked Health Centers: Update 1993, (Washington, D.C.: 1994). Data are for both school-based and school-linked health centers. CPO data are for the 1991-92 school year and are based on the 202 responses received from 510 SBHCs and SLHCs surveyed. Of these 202 health centers, 123 were school based and 75 were school linked. (The other four centers could not be classified.) Unless otherwise noted, all other CPO data we present are for SBHCs. (In March 1994, CPO changed its name to Advocates for Youth.)

[15]CPO; data on median budgets are for SBHCs only, while data for donated services are for both SBHCs and SLHCs.

Figure 1.2: SBHC Funding Sources, 1991-1992 School Year



[a]Medicaid/EPSDT may include state matching funds.

[b]Other includes school districts, SBHC enrollees, private insurers, and other state and local programs.

[c]State and Local Human and Social Services and Title V funds may not be mutually exclusive.

Source: Center for Population Options; n=202.

Federal Funding Sources

SBHCs receive funds from several HHS programs, but most federal funding comes from two sources: grants from the Maternal and Child Health Block Grant program (Title V of the Social Security Act, administered by the Public Health Service's (PHS) Maternal and Child Health Bureau (MCHB)) and service reimbursement monies from Medicaid (administered by HHS'

Health Care Financing Administration (HCFA)). HHS' Family Planning program (Title X of the Public Health Service Act, administered by the Office of the Assistant Secretary for Health) also provides grant funds that support services at some sites but to a much smaller extent. Federal officials could not identify the amount of dollars currently financing SBHCs because, except for a new grant program announced in May 1994, no existing federal program funds are specifically earmarked for SBHCs.

HHS announced the first federal program targeted specifically to SBHCs in May 1994. Two HHS offices are implementing the Healthy Schools, Healthy Communities grant program to support SBHCs. Under Public Law 103-112,[16] $3.25 million was provided in fiscal year 1994 for the Bureau of Primary Health Care (BPHC) to fund school-based primary care services for homeless and at-risk youth at 15 to 20 new sites.[17] Complementing this program, MCHB provided an additional $1 million of federal funds to these same sites for health education and promotion programs.[18] MCHB also funded a separate $1.5 million grant program to states and universities for SBHC staff development.

Additional HHS and Department of Education programs support other school health programs, such as health education, that may be provided in the schools but are not typically housed in SBHCs. An Education official told us that the Department's current efforts support locally designed school health initiatives that promote better student learning. For example, states and school districts may use funds authorized by the Goals 2000: Educate America Act (P.L. 103-227) to develop programs that provide students and families with coordinated access to social services, health care, nutrition, early childhood education, and child care.

SBHCs can also benefit from funds provided to 10 states by HHS' Centers for Disease Control and Prevention (CDC) under its Comprehensive School Health program. This program provides funds to a state's education and health agencies for planning, organizing, or developing statewide policies and resources to help schools implement comprehensive school health programs.

[16]The Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 1994.

[17]These funds were provided through the Outreach and Primary Health Services for Homeless Children program.

[18]Both BPHC and MCHB are in PHS' Health Resources and Services Administration.

Scope and Methodology

This report expands on preliminary information in our May 1994 report.[19] Our approach consisted of case studies, interviews with public and private officials, and a review of the literature. We conducted case studies at eight SBHCs in California, New Mexico, and New York. We chose locations to ensure that we visited urban and rural SBHCs in elementary, middle, and high schools. These locations were low-income communities that established SBHCs to deal with a multitude of concerns, including high rates of teenage pregnancy, drug and alcohol abuse, violence, and problems resulting from the effects of poverty. Following are the schools we visited (see app. I for more detailed information about each location).

California

- Luther Burbank Elementary School, San Jose
- William C. Overfelt High School, San Jose
- Thomas Edison High School, Stockton

New Mexico

- Espanola Valley High School, Espanola
- Escalante High School/Middle School, Tierra Amarilla

New York

- William Howard Taft High School, Bronx
- Intermediate School 136, New York
- Primary School 155, New York

During the 1992-93 school year, over 11,000 students attended these schools, of which over 3,700 used SBHC services, accounting for almost 20,000 individual visits. At the centers we visited, budgets ranged from $21,481 for a part-time rural SBHC at a school with 289 students to $285,000 for a full-time SBHC at a school with 3,300 students. At the centers, we toured the facilities and talked with health care providers, administrators, students, and parents. We interviewed health providers at backup facilities, other providers in the community, and state and local health and education officials. We supplemented our detailed case studies with visits to SBHCs in Colorado, Georgia, and Washington, D.C.

We discussed health and financing issues for SBHCs with HHS, Education, and local and national foundation and association officials, as well as other experts on SBHCs. Among the people we spoke with were representatives of the Robert Wood Johnson Foundation, American

[19]Health Care Reform: School-Based Health Centers Can Promote Access to Care (GAO/HEHS-94-166, May 13, 1994).

Academy of Pediatrics, National Association of State Boards of Education, Council of Chief State School Officers, CPO, and New York State Catholic Health Care Council. We conducted telephone interviews with administrators of SBHCs and managed care systems to obtain information on managed care systems' methods of reimbursing school centers and to determine the impact of managed care on SBHCs in Baltimore, Maryland; Minneapolis and St. Paul, Minnesota; Portland, Oregon; and Memphis, Tennessee. Additionally, we reviewed studies on the general status of children's health and on the experience of SBHCs. The scope of our study did not include evaluating the quality of care provided by SBHCs or the impact on students' health or educational status.

A draft of this report was reviewed by officials from the HHS Health Resources and Services Administration's Maternal and Child Health Bureau, Bureau of Primary Health Care, and Bureau of Health Professionals; Health Care Financing Administration's Medicaid Bureau; and Office of Disease Prevention and Health Promotion; and the Department of Education Office of Special Education and Rehabilitative Services, Office of Elementary and Secondary Education, Office of Intergovernmental/Interagency Affairs, and the Office of the Undersecretary. They generally agreed with our findings and made several technical comments and clarifications, which we incorporated as appropriate.

We did our work from April 1993 to October 1994 in accordance with generally accepted government auditing standards.

School-Based Health Centers Improve Children's Access to Health Care

Communities are using SBHCs to fill a niche in the nation's health care delivery system. SBHCs afford children easier access to needed health services by bringing providers to the children, furnishing free or low-cost services, and supplying the atmosphere of trust and confidentiality adolescents need. SBHCs do not, however, provide all health services required by children enrolled in school and cannot reach those who do not attend school.

SBHCs may also offer other benefits, such as improved educational attainment and the achievement of public health goals. States and local communities have demonstrated their support for SBHCs by allocating increasing resources to them. Nonetheless, research measuring the impact of SBHCs on health and education outcomes is sparse.

SBHCs Fill a Need for Children's Access to Health Care

SBHCs improve children's access to health care by removing financial and other barriers in the existing health care delivery system. These centers are a unique delivery option that gives children, especially those who are poor or uninsured, easy access to services. Providing services in schools is a particularly effective way to reach adolescents and also yields benefits for younger children.

Low-Cost Access to Providers

SBHCs provide students with health services at no fee or minimal cost, which helps children who lack health insurance and whose parents have difficulty paying for needed health services. Having access to free or low-cost services at school also helps children who are among the 21.4 percent of American children covered by Medicaid because they cannot always find physicians willing to treat them.

Even when a child has private health insurance, parents may be unable to pay the deductible or the insurance may not cover needed services. For example, most private insurers do not cover psychological or substance abuse counseling, services that SBHCs often provide. Some SBHCs offer or arrange for students to receive dental care. An HHS study indicated that 50 percent of children aged 5 to 17 do not have private dental insurance, and that, for those with insurance, copayments and deductibles may be as high as 50 percent of the cost of services.[20] One teenager we met at an SBHC said that her family did not have money to pay for dental services and that,

[20]"Toward Improving the Oral Health of Americans: An Overview of Oral Health Status, Resources, and Care Delivery," Public Health Reports, Oral Health Coordinating Committee, PHS (Nov.-Dec. 1993).

when a dental need arises, they must choose between seeing a dentist and paying for basic necessities like food and rent.

Increased Convenience for Students, Parents, and Providers

SBHCs improve children's access to health care by being more convenient for students. Children using the SBHC can quickly receive care and return to class instead of going home. Additionally, both SBHC providers and students told us that if the SBHC weren't there, ill students often would not seek treatment elsewhere, and their conditions might worsen. Bringing providers to students is especially important in rural and inner city communities with few health practitioners.

By being on the school site, SBHCs eliminate the need for parents to leave work or provide transportation, which may be unavailable or inconvenient. Health care facilities often have long waiting times, especially public facilities such as county hospitals, further increasing the time parents and students must take off from work and school. Both students and parents told us that waiting times at other facilities often range from 1 to 4 hours, even with an appointment. At one SBHC we visited, a student health survey found that, of the students who reported missing school for a doctor's appointment, nearly half missed at least six class periods. These problems are exacerbated in rural areas, where parents may have to travel considerable distances to pick up students, and providers may not be located nearby. At one rural SBHC, parents told us that some health services require drives of 60 to 100 miles or more. New Mexico officials said that SBHCs provide specific services that rural communities often lack, such as mental health services and suicide and violence prevention counseling.

SBHCs also make it easier for providers to contact and treat students. By being where the students are, SBHC staff are better able to follow up with students to ensure that they make and keep appointments with other providers and if necessary can call students out of their classes. This is especially useful when working with adolescents, who often do not make and keep needed appointments and may be deterred by long waits.

Additionally, being on site enables SBHC staff to work directly with teachers and parents to improve student health. An SBHC administrator told us that quick access to teachers, students, and parents, along with students' medical and school records, allows providers to better integrate information, develop diagnoses, and provide prompt treatment. SBHC providers said that teachers play an important role in identifying students

with potential health problems, referring students to the SBHC, and working with providers to help them better understand students' problems.

SBHCs Meet Adolescents' Needs for Trust and Confidentiality

SBHCs are particularly suited to meet the special needs of adolescents. To discuss their health concerns, teenagers require an atmosphere of trust and confidentiality. Additionally, their health care providers must be willing to ask probing questions to identify underlying problems. Both students and providers believe that other types of facilities often do not provide these conditions.

SBHC staff earn the trust of students by getting to know them, listening to their problems, and offering objective advice in a friendly, familiar environment. SBHCs also encourage trust by providing greater continuity of care; students can often see the same provider every visit, which they cannot always do at other types of facilities. Adolescents often will not discuss their problems until they spend time in the facility and feel comfortable with the staff. Providers noted that some students view SBHC staff as members of an extended family.

Once this trust is established, students coming in for apparently simple medical needs will often discuss more serious concerns—like depression, thoughts of suicide, or pregnancy—if the staff ask probing questions. At one center we visited, for example, a nurse practitioner talked with a girl who seemed overly withdrawn, who then revealed that she had been raped.

Students we talked with emphasized the importance of feeling comfortable with SBHC staff and especially appreciated the confidentiality of services. Both students and parents noted that adolescents often do not feel comfortable talking about personal health concerns, especially those involving risky behavior. Teenagers we talked with appreciated that SBHC staff do not scold or lecture them and noted that in some cases students have trouble talking with parents about their problems because they stem from their relationship with their parents. Confidentiality is particularly a concern in rural areas where many people are related and "everyone knows everyone else." A rural school superintendent told us that adolescents hesitate to go to the local clinic because they fear that someone will see them there and tell their parents.

Students told us that other facilities in their communities are impersonal and inconsiderate of adolescents' concerns. Providers at these facilities

tend to have less time to spend with patients, limiting their ability to identify the underlying causes of adolescents' problems. These facilities also cannot readily serve patients without appointments and may not ensure continuity of care by the same provider.

Providers from other community facilities generally agreed with these observations. One physician in private practice told us that pediatricians often do not ask probing questions, tending to address only the immediate concern rather than underlying issues. Another non-SBHC physician noted that pediatricians are accustomed to communicating with parents, not patients, and often are not willing to provide reproductive health services to teenagers confidentially. A private practice physician who also works at an SBHC told us that when she sees adolescents in her office, she usually has time only to treat acute symptoms, while at the SBHC she can spend time identifying additional problems or providing health education.

SBHCs Also Help Elementary School Children

While SBHCs provide particular benefits to adolescents, they can also help elementary school children. For example, monitoring and early treatment of chronic conditions, such as asthma, can prevent unnecessary hospitalizations and deaths. Health providers told us that mental health services are particularly effective at the elementary level when problems first appear because younger children are more malleable, feel less peer pressure, and are more open to discussing their problems than adolescents.

Parents and providers told us that like adolescents, elementary school children are more likely to use the SBHC than other health care facilities. A principal at an elementary school with an SBHC believes this occurs because parents and students are already familiar with the school and view the SBHC as part of the school. An SBHC provider at an elementary school noted that parents are often intimidated by other health facilities and find the SBHC a much friendlier place for their children to receive care. Parents of elementary school children told us that SBHC staff communicate well with the children and always seem to ask the right questions, adding that other providers tend to pay less attention to and seem to be less concerned about the children.

Centers Adapt to Different Cultural Needs

By providing bilingual, culturally sensitive staff, some SBHCs are better able to respond to the health needs of minority students. Some students experience cultural and language barriers that discourage them from going

to traditional health care facilities. For example, many families who are recent immigrants are not familiar with the health care system and do not know how to obtain services. Also, some of these families fear authority figures and thus do not seek services from the health care system. Providing services to students who have recently immigrated is especially important because they may not have received needed health care, such as physical examinations or immunizations, before coming to the United States.

Some SBHCs attempt to overcome these problems by providing bilingual staff and materials. For example, two SBHCs we visited had staff bilingual in English and Spanish and translated most forms and other written materials into Spanish. Another SBHC with large Hispanic and Asian populations translated many of its materials into both Spanish and Vietnamese and provided translators for Vietnamese, Cambodian, Chinese, and many other languages and dialects. An elementary school principal noted another reason for the importance of providing bilingual staff: even children who are comfortable with English as a second language often revert to their first language when injured or under stress.

Centers Cannot Reach All Children

SBHCs do much to improve children's access to health care, but they do not provide all needed services to all children. School centers are not always open during the summer or other times when school is not in session, and some are not open at all times the children are in school. SBHCs cannot provide the entire range of services students may need, and the comprehensiveness of referral networks varies. It can be particularly difficult for SBHCs to meet the total demand for mental health services either onsite or through referral to community providers.

Furthermore, SBHCs generally do not serve children who are not in school, such as those younger than age 5 or adolescents who have dropped out. About 383,000 students in grades 10 to 12 dropped out of school in 1992, and these young people may be especially vulnerable to adolescent health problems like sexually transmitted diseases and pregnancy.

SBHCs Can Provide Additional Benefits

SBHCs can also provide benefits beyond meeting children's basic needs for health care. These include improving children's ability to learn, providing a means for children to receive additional comprehensive services, and helping communities achieve public health goals.

By treating children's health problems, SBHCs may also improve children's educational achievements. Students with physical and mental health problems do not learn well, and poor school performance often discourages students from attending. A recent report on adolescent health cosponsored by the AMA concluded that

"education and health are inextricably intertwined. A teen who is depressed and doing poorly in school may begin relying on alcohol or drugs—and as a consequence, fall further and further behind. And a teenager with a baby is far more likely to be absent from school and eventually drop out."[21]

Others also stress the importance of good health to education. For example, a principal and a school counselor told us that by meeting children's health needs, SBHCs raise students' self-esteem, increase their connection with the school, and keep them from dropping out. An elementary school principal related that some students were placed in remedial classes when they could not keep up in their regular class because of undiagnosed or untreated vision problems. Sometimes these problems were undiagnosed or untreated for years, with severe consequences for the children's education. The SBHC helped reduce the number of such instances, but the principal told us that the center did not have sufficient resources to meet all students' needs for examinations and eyeglasses.

SBHCs can serve as a vehicle for providing more comprehensive services in schools. HHS reports that improving children's health requires a wide range of social and economic services. One SBHC we visited works with a dozen different outside organizations to provide services. These services include mental health counseling, alcohol and drug treatment, grief counseling, physical abuse counseling for women, and assistance from the federal Special Supplemental Food Program for Women, Infants and Children (WIC).[22] Another SBHC has a Medicaid eligibility worker on site and provides day care for the children of teen mothers.

By providing health education, preventive care, and treatment, SBHCs can help improve public health conditions. For example, a New York City SBHC we visited provides tuberculosis tests, immunizations, and physical exams to all new students of area schools, as required by the New York City

[21]Code Blue: Uniting for Healthier Youth.

[22]WIC provides supplementary food and nutrition education to eligible low-income pregnant, breast-feeding, and postpartum women; infants; and children up to age 5.

Department of Health. Similarly, a California SBHC we visited provides state-mandated immunizations and physicals to new students.

HCFA has promoted the potential role of schools in conducting outreach for Medicaid's EPSDT program. In an EPSDT guide for educational programs published in 1992, HCFA points out that SBHCs could play a role in providing important preventive and periodic care to eligible children.[23] The agency's EPSDT participation goals say that states should have screened 75 percent of eligible children by the end of fiscal year 1994 and 80 percent by the end of fiscal year 1995. Many states have had difficulty meeting the participation goals; for example, New Mexico had screened only 22 percent of eligible children by the end of fiscal year 1994. Officials in both Georgia and New Mexico told us that SBHCs could assist in their efforts to meet EPSDT goals.

Research Measuring Impact of SBHCs Is Sparse

Health care providers, educators, and parents told us that SBHCs bring a variety of benefits to students: improved school attendance and performance, lower drop-out rates, and improved health status. The resources that states and local communities have committed to SBHCs demonstrate their belief in the benefits SBHCs provide to children. For example, 27 states have allocated Title V Maternal and Child Health Block Grant money or general revenue to SBHCs.[24] However, data that measure the impact of SBHCs are generally not available.

Utilization data—such as SBHC enrollment levels, students' insurance status, and types of services used—suggest that SBHCs are filling an important function. Outcome data that reliably answer questions on the effects of SBHCs on students' immediate and long-term health and educational achievements are lacking, however. Also lacking is research comparing SBHCs with other health providers on measures such as cost-effectiveness and impact on health status. Many health professionals associated with SBHCs recognize the need for such information but have often lacked the resources to produce methodologically sound research. Conducting research on SBHCs is particularly challenging because of students' mobility and because of the long-range nature of some potential effects. The evaluation component of HHS' Healthy Schools, Healthy Communities grant program should contribute to developing data on SBHCs; it will include an outcome analysis examining impacts of SBHCs funded by the program on health and education indicators.

[23]States are required to conduct outreach to inform eligible Medicaid recipients about EPSDT.

[24]Robert Wood Johnson Foundation.

School-Based Health Centers Face Financing Issues

SBHC staff throughout the nation report that they encounter problems in financing their operations. School centers often rely on fragmented and sometimes short-term sources of funding to operate. Funding is further constrained because SBHCs have difficulty billing both private and public insurers. This problem is exacerbated by the growing tendency of state Medicaid programs to pay managed care systems to treat Medicaid beneficiaries because most state Medicaid agencies will not reimburse SBHCs for services provided to children enrolled in managed care. Some SBHC providers report that they do not have enough resources to meet children's needs, especially for mental health and dental services. Using varied approaches, some states are working with SBHCs and local communities to try to solve financing problems.

Financing Is Fragmented

SBHCs rely on a patchwork of state, local, private, and federal funding to cover their start-up and operating costs. Financing from private foundations has played a large role in establishing new centers, but grants are frequently short-term, leaving centers with an uncertain flow of funds after the first few years. The experience of San Jose School Health Centers, which operates eight SBHCs, illustrates this pattern. For school year 1992-93, San Jose's budget consisted of about $515,000 from 10 private and 4 state and local grants and about $100,000 in state and federal Medicaid funds. A 6-year annual private foundation grant for $100,000 expired that year; each of the other grants was awarded for 1 year. Thus Medicaid, which supplied only about 16 percent of the budget, was the sole continuing source of funds.

Problems in billing insurers further constrain SBHCs' ability to finance services. Local health and education officials cite the difficulty of handling the extensive paperwork process for billing Medicaid and private insurers due to the typically small number of SBHC staff. SBHCs we visited that were not sponsored by an established health care provider, such as a hospital or community health center, often lacked the administrative capability to implement a billing process. Centers with sponsors often relied on the sponsoring agencies' billing systems. Even these centers, however, sometimes faced problems in linking on-site billing to the sponsoring facility, especially when the SBHC lacked a computerized system to maintain patient data and generate bills. At one Georgia site, patient data had to be recorded twice: providers manually filled out forms and sent them to the sponsoring community health center, where the information was entered into the computer system for billing.

Additionally, private insurers may not cover certain services that SBHCs provide, such as preventive care and health education. Getting insurance reimbursement is further hindered because low-income families cannot pay insurance deductibles. Another problem with billing insurers is concern that adolescents will lose confidentiality if parents receive insurance statements. Because of these problems, some SBHCs do not bill third parties. Private insurance billing comprises only 1 percent of SBHC funding.[25]

Centers Have Difficulty Getting Medicaid Reimbursement

Although they serve many Medicaid-eligible children, SBHCs often face difficulties getting Medicaid reimbursement for the care they provide to these students. The growth of Medicaid managed care could further reduce Medicaid payments to school centers, because SBHCs cannot claim reimbursement for services they provide to children enrolled in managed care plans. Some managed care organizations are reluctant to include SBHCs in their networks, partly because they do not control the quality of care provided there.

SBHCs often serve large Medicaid-eligible populations. Four sites we visited reported that from 23 to 39 percent of students enrolled or using the center were insured by Medicaid. At three of those sites, the insurance status of another 29 to 59 percent of the students was unknown, which means that the Medicaid population of these SBHCs might be even larger.

SBHC administrators and providers identified three key problems that hindered their ability to get Medicaid reimbursement. First and foremost, providers do not always know which patients are eligible for Medicaid. Students may not know if they are eligible or may be reluctant to tell anyone if they are. Further, their eligibility status can change from month to month. Second, SBHC providers hesitate to use scarce administrative resources to handle what they consider to be a burdensome billing process. SBHCs that are managed by health care providers that already have administrative systems for billing report greater ease in getting Medicaid reimbursement. Finally, SBHCs' ability to receive Medicaid reimbursement may be limited by restrictions in state Medicaid programs. In Colorado, for example, services provided by nurse practitioners are not eligible for Medicaid reimbursement, yet nurse practitioners are key primary care providers at SBHCs.

[25]CPO; data are for both SBHCs and SLHCs.

Growth of Medicaid Managed Care Complicates Reimbursement for SBHCs

The trend toward managed care arrangements in the American private health care sector has spread to the Medicaid program as well, and a growing number of states use managed care organizations to provide services to people enrolled in Medicaid. As of June 30, 1994, 45 states and the District of Columbia were operating at least one managed care program for Medicaid beneficiaries.

SBHC staff and state and local officials whose programs support SBHCs emphasized their concerns about the relationship between SBHCs and both Medicaid and private managed care providers. State Medicaid agencies generally will not reimburse SBHCs for services they have already contracted with managed care plans to provide.

Managed care providers told us they are reluctant to incorporate SBHCs into their networks because of concern that they lack control over the type and quality of care provided. Issues related to the sharing of information, such as concern for patients' privacy and control over medical records, can further complicate cooperation between managed care providers and SBHCs. Additionally, it may not be in the financial interest of managed care organizations to reimburse school centers. When SBHCs do not receive reimbursement for care they provide to children enrolled in Medicaid managed care, they are in effect subsidizing the managed care plans.

SBHCs in a few locations have attempted to make arrangements with Medicaid managed care providers with mixed success. For example, SBHCs in Minneapolis and St. Paul, Minnesota, have reached agreements or are negotiating with all the major Medicaid managed care providers in their areas to reimburse SBHCs for services provided to students enrolled in their plans. California is conducting a project that may experiment with one or more of the following relationships between Medicaid managed care providers and school-linked Child Health and Disability Prevention (CHDP) services:[26]

- direct fee-for-service reimbursement by the managed care provider to the school provider for covered services;
- a cooperative relationship, such as the managed care provider's sending staff to provide CHDP services at the school site; or
- a protocol arrangement for the school site to refer patients to the managed care provider for required services.

[26]CHDP is California's EPSDT program.

Tennessee's new TennCare plan requires all Medicaid beneficiaries to enroll in managed care and to designate a primary care provider (PCP). TennCare encourages managed care organizations to include SBHCs in their networks; most of the managed care organizations, however, have not allowed students to designate a PCP independent of the one selected by their parents. For two Memphis SBHCs, this change in the state Medicaid program has resulted in an average annual loss of about $72,000 in Medicaid funds, or 40 percent of their budgets.

Most Medicaid managed care organizations in Multnomah County, Oregon, have refused to include the county's seven SBHCs in their networks. One managed care official said this was partly because the SBHCs are not true PCPs, since they do not provide a full range of care or provide for after-hours care when the SBHCs are closed. In Baltimore, Maryland, one Medicaid managed care provider reimburses the seven SBHCs operated by the city health department but only under certain conditions, such as when students have not yet seen their PCP or when the PCP is unavailable. A managed care official told us the plan hesitates to reimburse SBHCs further because it was already paying PCPs to provide services to plan enrollees and because it could not adequately control the quality of SBHC-provided care. Although the SBHC administrator believed they could resolve these issues, the managed care official said that her organization has no plans to expand its reimbursement of the SBHCs. Instead, the organization is planning to open its own SBHCs where it would serve both its own enrollees and other children. The HHS Office of Inspector General (OIG) recommended in a December 1993 report that PHS, HCFA, and the states should encourage cooperation between SBHCs and managed care providers.[27]

HCFA's Free Care Policy May Not Encourage School-Based Services

HCFA has a long-standing "free care" policy under which Medicaid will not reimburse providers for services given to Medicaid patients if the same services are offered for free to non-Medicaid patients.[28] HCFA bases the policy on federal Medicaid law, which requires state Medicaid plans to take available resources into account when determining which services to reimburse.[29] HCFA officials told us that the free care policy may contradict

[27]School-Based Health Centers and Managed Care, HHS OIG (OEI-05-92-00680) (Dec. 1993).

[28]The facility must have a fee schedule in place and bill other responsible third-party payers to bill Medicaid.

[29]Section 1902(a)(17) of the Social Security Act.

the agency's efforts to encourage school-based health services. Therefore, they have been re-examining the free care policy through a work group looking at Medicaid's payment provisions for school health services.[30]

There are exceptions to the free care policy. For example, Medicaid will reimburse for services provided to Medicaid enrollees regardless of whether the provider collects payment for services given to other patients if the Medicaid services are provided (1) by a facility that receives federal Maternal and Child Health Block Grant funds (provided the facility has an agreement with Medicaid) or (2) to disabled children with Individualized Education Plans or Individualized Family Service Plans under the Individuals with Disabilities Education Act (IDEA).[31]

Some officials who manage or work with school health programs believe it is inappropriate to apply the free care policy to SBHCs. For instance, one administrator responsible for several SBHCs said that the potential income from insurers and student fees is negligible. Because of the large percentage of students enrolled in private and public managed care plans and the reluctance of managed care providers to reimburse SBHCs for services provided to their enrollees, he would expect his SBHCs to receive little income from third-party reimbursement. In addition, the SBHCs are located in low-income areas, and uninsured students would likely pay little, if anything, for services under a fee schedule that takes into account family income.

The SBHC administrator said that he would also need to weigh the probability of limited income against the potentially negative impact on students of billing them or their insurers. Any fee, even $5, could, in his view, deter students from seeking services when they need them and compromise the qualities that make SBHCs unique, particularly the promise of easy access. The administrator explained that the SBHCs for which he is responsible receive grants to provide an underserved population with free health care, and these funds cover the cost of services that are not billed. He also expressed concern that students would lose confidentiality if parents received insurance statements.

[30]Work group members include representatives of federal, state, and local government and private organizations.

[31]These two exceptions are based on the following statutory provisions: for Title V, 42 U.S.C. 1396a (a)(11)(B)(ii); and for IDEA, 42 U.S.C. 1396b (c).

Funding Problems Limit Availability of Services

Administrators and health providers at some sites that we visited reported that budget limitations affect the services they can offer. For example, despite the demand for more services, some SBHCs cannot be staffed during all days or hours that the school is open.

SBHC providers consistently emphasized the large demand for mental health services at both elementary and high school facilities and told us that they could not always provide care or find providers in the community who would treat students. Both public and private health insurance coverage of mental health services tends to emphasize acute or emergency conditions rather than ongoing care, which limits SBHCs' ability to receive reimbursement for services their patients need. Many SBHCs in New York State eliminated social workers from their staffs because of funding constraints. Providers at one New York site said they use group sessions to work with students on certain problems because they do not have enough social workers to provide individual treatment for everyone.

Providers also reported great difficulty in meeting children's need for dental care. Few SBHCs can give care on-site: CPO reported that about 13 percent of SBHCs do so. Obtaining these services in the community can be difficult because of prohibitive costs, long waiting times for referrals, or a lack of dentists. Providers at one site said children had to wait 2 to 3 months for a nonemergency referral appointment with a dentist.

States Play Role in Addressing Financing Problems

Recognizing that local communities have difficulty financing SBHCs, some states have taken an active role in encouraging and supporting local efforts. The states where we conducted our case studies—New York, New Mexico, and California—are among those that have tried to address financing problems. Some state efforts are not targeted directly to SBHCs but rather support comprehensive service programs that can include health-related activities.

State efforts have been encouraged by other public and private agencies. The CDC's Comprehensive School Health Program promotes state-level participation by funding two full-time senior state positions—one in health and one in education—in 10 states to facilitate statewide planning, implementation, and evaluation of activities to help schools implement comprehensive school health policies and programs. In a recent grant program, the Robert Wood Johnson Foundation similarly emphasized the importance of state participation in funding SBHCs by including a

component that supports state-level efforts to reduce barriers to financing, organizing, and staffing SBHCs.

New York Supports Multiple Sites

New York has 140 SBHCs, many more than any other state; 112 of the SBHCs are in New York City. The state has actively supported SBHCs both by allocating funds to them and passing legislation that facilitates their operation. The New York State Department of Health is the principal funder of 110 of the centers. State-controlled funding for SBHC operations for the 1993-1994 school year included $3.64 million in state-appropriated funds. This appropriation increased to $6.5 million for the 1994-1995 school year; the increase was intended to enhance staffing and services at existing centers and establish five new SBHCs. The state also allocated $3.5 million in federal Maternal Child Health Block Grant funds to SBHCs each year.[32] Medicaid reimbursement is the only other source of federal funding supporting New York SBHCs; in the 1991-1992 school year, it represented about 10 percent of the total $8.6 million budget.

New York has supported SBHCs in several ways. The state, which first legislated authority for model SBHC programs in 1978, has implemented a state-level approval process for SBHCs and requires every SBHC in the state to be linked to a backup provider that provides 24-hour access to care. Additional 1981 legislation exempts SBHCs from meeting certain state requirements for medical facilities, such as minimum door widths. They are also exempt from the certificate-of-need process required of other facilities, which typically takes 2 years to complete. Instead, the state has used indicators of a high need for primary care—such as high levels of nonimmunized children and inappropriate emergency room use—to identify locations for SBHCs.[33] These waivers make it easier for SBHCs to be designated as state-approved medical facilities, which allows them to get Medicaid reimbursement.

Additional legislation that benefitted SBHCs included expanding the authority of nurse practitioners to provide certain services. This made those services eligible for Medicaid reimbursement. The state also absorbed the additional costs of four SBHCs whose private foundation monies ended in 1992. Further, in 1993, the state authorized all SBHCs to

[32]New York State received $41.4 million in its fiscal year 1994 Maternal and Child Health Block Grant.

[33]Inappropriate emergency room use includes relying on the emergency room as a regular source for primary care, an inadequate and costly way to provide regular care to children. For additional information on emergency room use, see GAO's report, Emergency Departments: Unevenly Affected by Growth and Change in Patient Use (GAO/HRD-93-4, Jan. 4, 1993).

claim the Medicaid rates of their backup facilities. Previously, SBHCs received a special, lower Medicaid rate for patient visits. This change was expected to increase Medicaid funding for most centers.

New Mexico Actively Supports SBHCs

Like New York, New Mexico has used Maternal and Child Health Block Grant funds to support its SBHCs. For 1994, the state allocated $218,000 of these funds in contracts ranging from $4,000 to $20,000 to support 23 SBHCs.[34] An additional six SBHCs are supported primarily by other New Mexico Department of Health funds or private funds. The state places high priority on maximizing the use of available Title V dollars to support SBHC activities; the funds are mainly used to pay nonphysician primary care provider salaries.

The state requires every SBHC to identify a health care provider to which it can refer students for treatment the SBHC cannot provide. The state Medicaid program also requires a referral network to be in place before the SBHC can be eligible for Medicaid reimbursement.

CDC's Comprehensive School Health Program is funding positions in New Mexico's Departments of Health; Education; and Children, Youth and Families. These departments are charged with creating better support at the state and local level for coordinating school health programs that have been the responsibility of separate departments. They join other agency staff in a State Interagency Committee, initiated by the governor in 1993, which oversees all comprehensive school health programs in the state. Because of the CDC program and related projects, the state is developing a pilot comprehensive school health program in one school district, scheduled to begin in January 1995. Officials hope to receive additional state funds that would allow them to expand the pilot project to four more sites during the 1995-1996 school year.

New Mexico has also begun other efforts to expand health services in schools. For instance, the state is training school nurses to complete EPSDT screenings. At the completion of our work, the state had signed agreements with seven school districts to implement this program.

California Supports SBHCs Indirectly

The 26 SBHCs in California have received less direct support from the state government than the centers in New York and New Mexico, but the state supports related efforts. State funding for SBHCs has generally come from

[34]New Mexico received $4.6 million in its fiscal year 1994 Maternal and Child Health Block Grant.

Medi-Cal and state tobacco tax dollars, although the amount of funding going to SBHCs is unknown.[35] For certain sensitive services, such as family planning services, Medi-Cal allows teenagers to qualify on the basis of their own income rather than their parents' income. The state cannot receive federal reimbursement for these services so funds them alone. Title V funding, which is widely used in the other two states, has not funded any California SBHCs; however, the state is using Title V dollars to develop a computerized billing process for SBHCs.

California has created a separate school-related project called Healthy Start.[36] This program is a statewide effort to place comprehensive support services at or near schools, with an emphasis on integrated health, mental health, social, educational, and other services for children and their families. The state allocated $55 million from July 1, 1991, through June 30, 1993, to fund planning and operational grants that cover 890 elementary, middle, and high schools.[37] The program received an additional allocation of $20 million for grants to be awarded by June 30, 1995.

Conclusions

The people who administer and provide care at SBHCs consistently identify a lack of stable financing as their greatest problem. Public and private health insurance plans that cover children enrolled in SBHCs could be important sources of reliable funding for the centers, but getting reimbursement from both Medicaid and private insurers often presents a difficult challenge for SBHC staff.

SBHCs that are closely linked with established health care providers, such as hospitals and community health centers, generally find it easier to bill Medicaid and other insurers than do centers without such an affiliation. The established providers usually have a billing system in place and can take over this function for the SBHCs. Connection with an established health care institution also gives an SBHC the advantage of a readily available referral network to provide needed services beyond the capacity of the SBHC, such as 24-hour emergency care or specialized medical care. This network of care could also increase SBHCs' attractiveness to managed care providers.

[35]Medi-Cal is California's Medicaid program.

[36]The program was enacted under the Healthy Start Support Services for Children Act of 1991.

[37]Grants are generally awarded to a body that includes a consortium of schools.

SBHCs that follow a variety of organizational models are operating successfully. However, the administrative and treatment advantages that come with affiliation with an established health care provider suggest that forming such an alliance from the outset can give an SBHC greater stability and enhance the range of health services it can offer its patients.

SBHCs serve many adolescents and younger children who are covered by Medicaid, and HCFA supports using such centers to provide needed care to children. Easing SBHCs' ability to get reimbursement for services they provide to Medicaid beneficiaries could improve the centers' financial viability. We agree with the recommendation of the HHS OIG that, as states enroll an increasing number of children covered by Medicaid in managed care plans, it would be beneficial for HCFA to encourage state Medicaid officials to promote cooperation between these plans and SBHCs serving their enrollees.

Another positive step that could help SBHCs get Medicaid reimbursement is HCFA's reexamination of its free care policy. If HCFA were to create an additional exception to Medicaid's free care policy for services provided by SBHCs, SBHCs could bill Medicaid for care given to children enrolled in Medicaid regardless of whether they collect fees for care given to other students.

School-Based Health Centers Face Other Common Problems

Communities that wish to establish and maintain SBHCs often face problems other than financing. One difficulty is finding an adequate supply of appropriately trained personnel to provide primary care to students. A second is controversy stemming from concerns that SBHCs would provide reproductive health services that some members of the community consider inappropriate. Finally, SBHC staff lack easy access to information that would help them operate their centers.

Appropriately Trained Staff Difficult to Recruit and Retain

The shortage of primary care providers in the United States is reflected in the increasing number of unserved and underserved rural and inner city areas.[38] SBHCs face a particularly acute shortage because they often need providers with special qualifications, such as training in work with adolescents or bilingual ability. The main health care providers at SBHCs are nonphysician primary care providers—that is, physician assistants and nurse practitioners. SBHCs are hindered in their efforts to recruit and retain these practitioners because the demand for nonphysician primary care providers exceeds the supply, especially for providers with appropriate skills to work in a school setting. SBHCs' noncompetitive salaries and working conditions exacerbate the situation.

State officials we visited consistently identified the recruiting of SBHC providers as a problem. For instance, New York officials reported a need to expand the number of nonphysician primary care providers to staff SBHCs. To increase the supply, they applied for private foundation funds to develop targeted training programs, practicum placements, and incentives for employment in school-based settings. Similarly, California state officials said that the demand for nurse practitioners and physician assistants with experience treating school-age children exceeds the supply. Fewer than 40 nurse practitioners with school health experience graduate from approved programs each year in California. Health officials in New Mexico are working with the state's school of nursing to try to increase the supply of nurse practitioners. The school had only nine people enrolled in its program in November 1993.

The nonphysician primary care shortage is exacerbated for SBHCs because they cannot offer competitive salaries and working conditions compared with those of other health care settings, such as hospitals and HMOs. For example, in New Mexico SBHC nonphysician primary care providers are often reimbursed directly by the state's Maternal and Child Health office,

[38] An Agenda For Health Professions Reform, HHS, PHS (Feb. 1993). Primary care providers include family physicians, general internists, pediatricians, nurse practitioners, physician assistants, and certified nurse midwives.

and state regulations limit state-funded nonphysician primary care salaries to $20 per hour, half the rate in the private sector. Similarly, some SBHCs in New York City have been unable to match the salaries nurse practitioners can earn in other settings. State officials in New York told us that the prevailing compensation for a nurse practitioner in New York City—where most of the SBHCs are located—was about $75,000 to $85,000 in 1994. SBHCs in New York City are at a competitive disadvantage because their typical compensation for nurse practitioners ranges from about $55,000 to $65,000. In some instances, the SBHC sponsor, for example, a hospital, pays the difference between the amount available for salary under the state-awarded contract for SBHC operations and the salaries paid by the sponsor to its other employees. Other facilities without these resources, such as community health centers, have had vacancies for SBHC nurse practitioners that they cannot fill. The part-time status of some SBHC positions further limits salaries.

School locations in potentially dangerous urban neighborhoods or remote rural areas further hamper SBHCs' recruiting efforts. We saw the effect of this in New Mexico, where seven rural sites wishing to open SBHCs have been unable to find providers. One of these—only 20 miles from Albuquerque—could not use a state grant because of its inability to recruit a nonphysician primary care provider during a 2-year period. In California, we were told that some nonphysician primary care providers come to SBHCs to gain experience, then leave to work for a private facility.

Another factor that may limit the appeal of SBHCs is that providers must work more autonomously there than in other settings. They may be isolated from colleagues and lack access to training and opportunities to exchange ideas with other providers.

Federal Programs Focus on Training and Recruiting

HHS' Health Resources and Services Administration sponsors several programs designed to enhance the skills of school health care providers, some of whom might work in SBHCs. For example, MCHB supports training in adolescent health issues, and the Healthy Schools, Healthy Communities' staff development grants are intended to help prepare health care providers and education personnel to implement comprehensive school health programs. Additionally, the Bureau of Health Professions supports programs that provide training to nurses who work in school settings.

Another potential source of nonphysician primary care providers for SBHCs is the National Health Service Corps (NHSC).[39] Other health settings for the underserved, such as community and migrant health centers, rely on physicians and other health professionals recruited from NHSC to overcome problems similar to those faced by SBHCs. Like SBHCs, these other settings cannot offer competitive salaries and sometimes require personnel to work at facilities located in less desirable areas. Approximately half of the physicians working in community and migrant health centers in 1989 were recruited from NHSC.

SBHCs have never applied to obtain NHSC staff, but NHSC officials we talked with were receptive to participation by SBHCs that meet program requirements. They noted that such SBHCs could benefit from ongoing changes in the program. For its primary care placements, NHSC recently expanded its earlier focus on physicians to include nonphysician primary care providers. The 1990 reauthorization act for the NHSC (P.L. 101-597) reserves 10 percent of the appropriation for scholarships and loan repayments to people studying for certification as a nurse practitioner, nurse midwife, or physician assistant. In addition, NHSC expects to increase the number of placement slots fourfold between 1994 and the year 2000. An NHSC official told us that this increase would expand the opportunity for SBHCs to participate in the program. NHSC wants to add more NHSC-approved sites to its roster to accommodate all of the health personnel seeking placements.

Controversy Over Reproductive Health Services Constrains SBHCs' Ability to Meet Some Adolescent Health Needs

Many adolescents are sexually active. Because they are at risk for disease and pregnancy, they could benefit from access to reproductive health services. Some community members, however, consider it inappropriate for this age group to have access to these services in schools. The resulting controversy has sometimes affected the funding, services, or operations of SBHCs. SBHC proponents have found ways to mitigate the potential effects of opposition and controversy.

Sexually active adolescents are at risk for problems associated with unprotected sexual intercourse. HHS recently reported that over half of all high school students are sexually active, and 80 percent of sexually active

[39]The Bureau of Primary Health Care's National Health Service Corps program, established by the Health Professions Educational Assistance Act of 1976 (P.L. 94-484), encourages the placement of health professionals in geographic areas and public health programs that lack health personnel. The program encompasses two major activities: a field program that places qualified health professionals in shortage areas, and scholarship and loan repayment programs that provide educational assistance to students of various health professions in return for an obligated service period.

girls reported that their partners do not use condoms, the only contraceptive method known to protect against HIV infection. Every year, more than 1 million adolescents get pregnant, representing nearly 1 teenage girl out of every 10 in the United States, a rate that is at least twice as high as in other industrialized countries. Additionally, three million adolescents contract a sexually transmitted disease each year. The incidence of gonorrhea increased 325 percent among 10- to 14-year-olds and increased 170 percent among 15- to 19-year-olds between 1960 and 1988. Furthermore, CDC reported a total of 1,412 cases of AIDS among adolescents through September 1993.[40]

The reproductive services that adolescents use include counseling, gynecological exams, pregnancy testing, sexually transmitted disease diagnosis and treatment (including HIV testing), prescription and distribution of contraceptives, and prenatal care. Many SBHCs provide all or some of these services, although the majority do not provide contraceptives. (For additional information on SBHC services, see fig. 1.1.)

Opposition to some reproductive health services expressed by groups of citizens, elected officials, and religious leaders has led some centers to limit or eliminate family planning services, move their operations off the school campus, or not open. Other sites have had their funding withheld. Several sites that we visited had encountered opposition at some point.

Opponents stopped two separate efforts to establish SBHCs in neighboring towns in Louisiana. One proposed site had the backing of a medical facility and the school board, and the second site—which also had school board support—had been approved for state funding. While proponents of the SBHCs stressed a need for health services and psychological counseling, opponents expressed concerns about the loss of parental involvement in an adolescent's health care decisions and adolescents' potential ease of access to birth control and abortion services. Opponents also suggested that a school center would duplicate existing health services.

Sites have initiated several actions to garner support for SBHCs. For example, the sponsors of an SBHC we visited in California took steps—before opening the center—to answer the concerns of those who oppose some SBHC services. Their efforts included forming a facilitating

[40]CDC noted that while the number of adolescents with AIDS was relatively small, many additional young people are infected with HIV. Since one in five reported AIDS cases is diagnosed in the 20-to 29-year-old age group and the median incubation period between HIV infection and AIDS diagnosis is about 10 years, many people who were diagnosed with AIDS in their twenties became infected as teenagers.

committee that included representation from a wide range of community groups, conducting a needs assessment, promoting parental support, educating the school board about the children's need for services, and developing a parental consent procedure that allowed parents to restrict the services their children could receive. The SBHC opened without opposition.

A school board in New Mexico prohibited an SBHC from continuing to dispense contraceptives in response to community concerns. The decision was reversed after the school experienced an apparent increase in the number of teen pregnancies, parents expressed strong support for the services, and students collected about 1,000 signatures on a petition.

Getting Guidance Is Difficult

Communities have difficulty getting information on establishing new SBHCs and solving problems at existing centers. No central source of information exists on SBHC operations and potential funding sources.

People with experience in operating SBHCs or otherwise knowledgeable about them said that they regularly receive requests for information on issues such as the relationship between the school and SBHC, staffing, services, funding, outreach, quality assurance, and budgeting. However, experienced SBHC staff sometimes lack time to answer the large number of requests for assistance. Officials at one SBHC site began charging a consultation fee because requests for information required so much of their time.

Both potential and established centers have difficulty getting information on funding sources because of the multitude of programs affecting varied school health issues, particularly at the federal level. SBHC officials told us that centers would also benefit from information on successful practices for providing care, doing outreach, and financing SBHCs, including examples of coordination between managed care providers and SBHCs.

No Central Point Exists for Information at the Federal Level

HHS does not have a focal point to handle outside inquiries or to centralize information on federal programs for SBHCs. An HHS official told us that staff regularly receive technical assistance requests from officials interested in school-based services but said that the agency lacks the infrastructure to handle these requests. In its December 1993 report, HHS' OIG recommended that HHS establish contacts in its agencies for interested parties outside the

department who required information about SBHCs, but, as of October 1994, HHS had not implemented this recommendation.[41]

A multitude of federal programs support health-related activities in schools, including health services, health education, and staff training. Multiple agencies—and offices within these agencies—have responsibility for these programs. In June 1992, HHS and the Department of Education began an effort to coordinate and improve the delivery of these services in schools by initiating the Interagency Committee on School Health. In April 1994, the Secretaries of both departments issued a joint statement that announced their cooperative efforts. Committee members identified 23 HHS, Education, and Department of Agriculture programs as potential federal funding sources for school health programs. In addition, they have formed three subcommittees and multiple work groups to study various issues, including technical assistance, financing, and school-based service models. The Health Services Subcommittee is examining ways the federal government can support school-based health services, including actions related to funding.

Conclusions

SBHCs' difficulty in attracting an adequate supply of qualified providers could grow more serious with a substantial increase in the number of SBHCs. HHS' support of training programs for school health care providers may help expand the number of skilled providers capable of working in SBHCs. Furthermore, NHSC officials' willingness to consider participation by SBHCs could make available to school centers an additional pool of caregivers; at the same time, SBHCs would provide additional placement opportunities for NHSC practitioners.

Another problem for SBHCs and people who would like to establish new SBHCs is the lack of a central source of information on the wide range of issues that affect SBHC operations, including financing, staffing, and quality of care. SBHCs first developed at the grassroots level, with states and local communities creating programs to respond to the particular needs and circumstances in their locales. As interest in using SBHCs to bring health care to children has expanded, so have the quest for information about how to establish and operate SBHCs and the desire to learn from the experiences of pioneering centers.

HHS could fill this information gap if it were to follow the recommendation of its OIG and establish a focal point in the department to respond to

[41]School-Based Health Centers and Managed Care.

requests for information on SBHC operations and the many federal programs that are potential sources of financial support for SBHCs. This focal point could also organize a technical assistance function to help communities develop SBHCs that best meet the needs of their families. An additional contribution the focal point could make would be to work with federal health research agencies to include in the national research agenda questions about the best ways to provide health care to children and the role and impact of SBHCs.

Descriptions of School-Based Health Centers

The following information was provided by the staffs of the SBHCs we visited and state officials. Health center staff include both full-time and part-time personnel. All data are for the 1992-1993 school year unless otherwise noted.

Thomas Edison High School, Stockton, California

School Profile

Population: 2,308 students in grades 9-12; 40 percent Hispanic, 33 percent Asian, 17 percent African-American, 6 percent white, 4 percent other

Health Needs: The county has a high teen pregnancy rate. A student health assessment indicated high levels of unprotected sex and alcohol, tobacco, and drug use, and a need for health education and mental health services.

Operations

Year opened: 1993

Linked facility: Health Service Agency

Hours: Approximately 40 hours per week; open during summer

Staff: Nurse practitioners, physician assistant, school nurse, medical assistant, health clerk, physician, mental health workers, nutrition counselor, site coordinator

Health services: Immunizations, physical exams, minor illness/injury treatment, chronic illness test/management, prescriptions (written and dispensed), lab tests, reproductive/family planning services; various health education and counseling programs

Annual budget: $192,575 (1993)

Funding sources: Federal—Medicaid; state—multiple state programs; other—private insurance, private foundations

Utilization (1993-94 school year): 1,750 consent forms on file; 1,049 students involving 2,272 visits

Luther Burbank Elementary School, San Jose, California

School Profile

Population: 367 students in grades kindergarten-8; 64 percent Hispanic, 20 percent white, 6 percent African-American, 5 percent Asian, 5 percent other

Health needs: The community has high poverty, a high crime rate, and high drug use. The school district is in an unincorporated area with few resources.

Operations

Year opened: 1991

Linked facility: Hospital

Hours: 7 hours per day, 3 days per week; open during summer

Staff: Nurse practitioner, medical assistant, physician

Health services: Immunizations, physical exams, acute/chronic illness treatment, prescriptions (dispensed), lab tests

Annual budget: $52,576 (fiscal year 1993)

Funding sources: Federal—Medicaid, state—multiple state programs, other—private foundations

Utilization: About 275 consent forms on file, 102 students involving 383 visits

Overfelt High School, San Jose, California

School Profile

Population: 1,950 students in grades 9-12; 61 percent Hispanic, 14 percent Asian, 5 percent African-American, 5 percent white, 15 percent other

Health Needs: The school is in an area of lower-middle- to low-income housing. Census data from 1985 show 60 percent of families in the area on Aid to Families with Dependent Children and 30 percent of households headed by a single parent.

Operations

Year opened: 1986

Linked facility: Hospital

Hours: Approximately 40 hours per week; not open during summer

Staff: Physician assistant, medical assistant, physician, pregnancy prevention counselor, mental health counselors, substance abuse intervention and treatment staff

Health services: Immunizations, physical exams, acute/chronic illness treatment, prescriptions (dispensed), lab tests, family planning, pregnancy testing, prenatal care, sexually transmitted disease diagnosis and treatment, health education, counseling

Annual budget: $97,052 (fiscal year 1993)

Funding sources: Federal—Medicaid, state—multiple state programs, other—private foundations

Utilization: 466 students involving 3,115 visits

Espanola Valley High School, Espanola, New Mexico

School Profile

Population: 1,238 students; 83 percent Hispanic, 10 percent white, 7 percent Native-American

Health needs: The school is located in an impoverished area, with a high incidence of drug abuse, alcoholism, and violence. The county has the highest teen pregnancy rate in the state. The SBHC was established to address the teen pregnancy rate and the spread of sexually transmitted diseases.

Operations

Year opened: 1985

Linked facility: None

Hours: 35 hours per week; not open during summer

Staff: Nurse practitioner, registered nurse, physician, secretary

Health services: Physical exams, primary and preventive health care, prescriptions (written and dispensed), family planning, health education, alcohol and drug counseling, counseling on adolescent concerns, various workshops and teen groups.

Annual budget: $80,000 (1993-94 school year)

Funding sources: Federal—Maternal and Child Health Block Grant, state—state grant; other—school district

Utilization: 619 students involving about 4,500 visits

Escalante High School/Middle School, Tierra Amarilla, New Mexico

School Profile

Population: 160 high school students (grades 9-12) and 60 middle school students (grades 6-8) on a shared campus. The SBHC also serves 75 middle school students from a nearby town. Of students using the SBHC, 82 percent are Hispanic and 18 percent are white.

Health needs: The community is in a rural area and has a large low-income, minority population with a high incidence of hypertension, heart disease, obesity, alcohol abuse, and diabetes.

Operations

Year opened: 1992

Linked facility: None

Hours: 15 hours per week (spread over 4 days); not open during summer

Staff (1993-94 school year): Nurse practitioner, registered nurse, public health nurse, health educator, clerk/coordinator

Health services (1993-94 school year): Immunizations, sports physicals, primary care, prescriptions (written and dispensed), family planning, health education

Annual budget: $21,610 (1993-94 school year)

Funding sources: Federal—Maternal and Child Health Block Grant; state-state grant; other—private foundation, school district

Utilization: About 65 students involving 684 visits

Intermediate School 136, New York, New York

School Profile

Population: 1,057 students in grades 6-9; 60 percent Hispanic, 40 percent African-American

Health needs: The community's poverty rate is much higher than in other sections of New York City and is one of the major drug areas in the city. The area also has a high teen pregnancy rate. Seventy-nine percent of students using the SBHC report having no regular source of medical care.

Operations

Year opened: 1991

Linked facility: Hospital

Hours: 40 hours per week; open during summer

Staff: Nurse practitioner, health educator, physician, social workers, health advocate, office manager, numerous other part time staff

Health services: Immunizations, physical exams, trauma response, first aid, chronic illness management, prescriptions (written), lab tests, health education, stress management, counseling, crisis intervention

Annual budget: $275,000 (1993-94 school year)

Funding sources: Federal—Medicaid, other—New York City Department of Health (matched in part by the state)

Utilization: 1,105 consent forms on file, 902 students involving 5,022 visits

Primary School 155, New York, New York

School Profile

Population: 468 students in grades kindergarten-6 plus 100 students in a collocated "alternative" middle school; 70 percent Hispanic, 25 percent African-American, 3 percent white, 2 percent Asian

Health needs: The community is one of the poorest in the area, with high unemployment, poor education, and a high number of single-parent households. About one-third of area residents receive public assistance.

Operations

Year opened: 1982

Linked facility: Community Health Center

Hours: Approximately 38 hours per week; open during summer

Staff: Pediatric nurse practitioner, school health workers, physician, program director, school health secretary

Health services: Immunizations, physicals exams, screenings, dental services, episodic care, first aid, chronic illness management, prescriptions (written), health/nutrition education, psychosocial counseling

Annual budget: $80,200 (1993-94 school year)

Funding sources: Federal—Medicaid, Maternal and Child Health Block Grant; state—multiple state programs; other—private insurers

Utilization: 435 consent forms on file, 346 students involving 1,118 visits

William Howard Taft High School, Bronx, New York

School Profile

Population: 3,300 students in grades 9-12; 50 percent Hispanic, 40 percent African-American (including Caribbean), 10 percent other

Health needs: The school is located in the poorest U.S. congressional district in the country. The area around the school has one of the highest rates of HIV infection in the country. Over 75 percent of students using the SBHC have no health insurance, and many lack basic health care. Providing care is complicated by a high level of student transience.

Operations

Year opened: 1987

Linked facility: Hospital

Hours: 40 hours per week; not open during summer

Staff: Nurse practitioner, coordinator/social worker, licensed practical nurse, health aides, outreach worker, social worker, physician

Health services: Immunizations, physical exams, screenings (dental, vision, hearing), chronic illness care, prescriptions (written), routine lab tests, family planning information, pregnancy tests, sexually transmitted disease treatment, health education, nutrition counseling, mental health counseling, general social services

Annual budget: $285,000

Funding sources: Federal—Medicaid, Maternal and Child Health Block Grant; state—multiple state programs; other—Bronx-Lebanon Hospital, United Way, private insurers

Utilization: 2,486 consent forms on file, 948 students involving 4,163 visits

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Acknowledgments

In addition to those named above, the following individuals made important contributions to this report: Joe Sikich, Evaluator; Frederick K. Caison, Senior Evaluator; Robert G. Crystal, Assistant General Counsel; Sylvia L. Shanks, Senior Attorney Advisor; and Cynthia Schilling, Reports Analyst.

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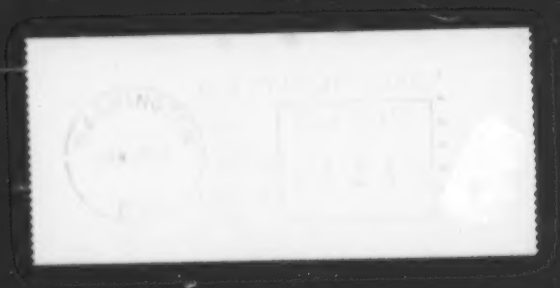

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